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ABSTRACT

This paper describes the multidisciplinary group therapy teams that provide services to older persons in board and care residences in the catchment area of Thalians (California) Community Mental Health Center. It reports on the manner in which the decision to form teams was arrived at, the process by which the teams were established, and the salient results of the experience. Additionally, it suggests the major issues to be considered by others interested in pursuing this strategy. Three recommendations are made: (1) training for realistic expectation (on the part of both staff and clientele) should precede the team's entry into the residence; (2) this training should also provide team members with a variety of group formats useful for working with an older, institutionalized population; and (3) the importance of regular team meetings (to discuss techniques and case issues) should be emphasized. (Author)

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Development of TOUCH TEAMS*

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This presentation describes the multi-disciplinary group therapy teams that provide services to older persons in board and care residences in the catchment area of the Thalians Community Mental Health Center. More specifically, it reports on the manner in which the decision was arrived at to form teams, the process by which teams were established, and the salient results of this experience. Additionally, it suggests the major issues to be considered by others interested in pursuing this strategy.

A. BACKGROUND

The therapy teams are based in an NIMH Community Mental Health Center whose guidelines specify a geographically defined catchment area. Within our catchment area there is a larger proportion of older persons than in any other urban area in the country. The proliferation of residential care (or board and care) homes and Nursing or Convalescent homes in our catchment area is an outgrowth of this concentration of the aged.

Residency in homes in our area ranges from fewer than six to more than one hundred persons. Nursing homes average between 50 and 100 residents. The residents in board and care homes are usually over 65 years of age; they are no longer able to live alone, and have no relatives willing or able to accept them into the existing family structure.

We knew, even before the pilot therapy team was begun, that many of the residents in congregate situations were leading lives of curtailed activity and enforced inactivity. One needs only to consider their situation:

-- These are older persons. Their physical problems (for some, the beginnings of loss of memory, hearing and vision) seriously limit their activities of daily living. These limitations increase feelings of depression and alienation.

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-- Physical and psychological constraints and pressures are exacerbated by the living conditions in a board and care home. Here the resident often ceases to feel like an individual.

-- Loss of one's home contributes to loss of identity. Together these lead to a constellation of symptoms which can result in gradual deterioration and serious medical and psychiatric problems.

-- Partially as a result of placement in a home, relationships in families deteriorate, and family conflicts are intensified.

We recognized the strong need for clinical and preventive mental health services to be delivered to the older population in our area and particularly to those older persons in board and care homes (and other service centers) throughout the community. In settings like congreate care homes, only the rare person has both the physical capacity and emotional resources to escape debilitating effects. Deprivation is complete in all spheres except those of food, lodging and minimally organized recreation.

In our project's beginning we proposed to connect the needs of older persons in board and care facilities with the service of group therapy teams. At first, and at the very least, we thought to bring the residents of homes to the Outpatient Service of our Center.

However, despite isolation from friends and family and the often severe depression accompanying this form of living--and despite the onslaught of aging under these conditions--these persons had great difficulty accepting the notion that psychiatric intervention would be useful. To these reservations were added the very real difficulties of transportation.

We quickly saw that we could not expect the aged person to present him/herself for treatment in a psychiatric setting. That is, we saw that the need for the delivery of group therapy to the place of residence of

the older person was essential; the needs of these persons could best be met by the delivery of services into the community.

Plans and notions to bring the groups of older persons to a therapeutic setting were inadequate to the reality; therefore we took therapeutic teams to groups of older persons in congregate home settings.

B. TOUCH TEAMS

These teams consist of a psychiatric resident, an experienced mental health professional (a clinical social worker or a psychologist), and one or more volunteers. The volunteers in these teams are trained to administer a standardized needs assessment instrument (at present the OARS Instrument-- cf. presentation by Dr. Susan Harris) are sensitized to group processes, and are beginning to provide individualized case-management services to individual residents.

Building the therapeutic teams--TOUCH Teams, as they came to be called--was a matter of intense concern. Team members participated in seminars, held discussions among themselves, and planned for their own evaluation. They operated in the recognition that the therapy they were to deliver was addressed to the unmet needs of the residents of the homes. It was the expectation that all personnel in these teams would function together to provide direct psycho-social service to residents through the vehicle of the group.

Once the facilities within which the TOUCH Team therapy groups were to function were targeted, two procedures were followed to assure the success of the project and to secure the cooperation of the personnel in the various facilities:

Conferences were held with caregivers;

Processes were set in motion to establish groups.

In order to facilitate the entry of TOUCH Teams into the selected facilities, a number of meetings were held with the proprietors and staff of these homes. The golas of these meetings were as follows:

-- To outline the team entry plan for proprietors and staff and to explore their feelings about outside professionals entering their domain;

-- To identify mutual goals of the TOUCH Teams and the homes;

-- To discuss the impact of TOUCH Teams on the normal rhythm of the home (this included the possible impact of increased resident assertiveness);

-- To identify and discuss any negative feelings of congregate home staff regarding aging, illness, and death; and to discuss and provide means of dealing with such feelings;

-- To establish a contract about the scheduling and location of TOUCH Teams; and

-- To gather information about residents which would be useful in establishing participant membership in the TOUCH Teams.

(We found that the consulting participation of therapists who had formerly worked in these settings was especially helpful in these preparatory sessions with proprietors and staff persons.)

The identification of possible resident participants was based on the following considerations:

-- The request from a proprietor for intervention and assistance with specific residents;

-- Staff identification of troubled and troublesome residents;

-- Resident self-selection or request for relevant services.

Possible members of the resident group--identified through meetings with proprietors and staff or through resident indication--were interviewed briefly by members of the therapy team. The OARS Instrument was administered

by trained volunteers, and the results were reviewed by M.D.s who then provided a tentative diagnosis of condition. (If a potential participant refused to cooperate in an OARS assessment--or was unable to provide some required information--a family member, or some significant other, was approached for the information.) Through these measures, and a team consideration of their results, the participants were selected.

C. THE TOUCH TEAM EXPERIENCE

We have had TOUCH Teams functioning in congregate homes for the past 15 months. Our experience might be helpful for others considerings such activities.

Over this period all Team members have altered their expectations and their stance with regard to appropriate therapy for this older population; they have, in addition, begun to utilize creative and innovative approaches in their therapy. Most Team members anticipated working within a traditional therapeutic mode with an emphasis on insight and feelings. Their expectations were that board and care residents could engage in that process.

TOUCH Team members reported, however, that they were often unprepared for and overwhelmed by the apathy, isolation, and mental deterioration of patients. Team members became acutely aware of their own vulnerability and of the possibility that they might internalize feelings of helplessness and hopelessness which existed among the residents with whom they dealt.

This realization--essentially one that expectations had been unrealistically high--resulted in teach Team's re-evaluation of its response to residents' requests for help. For example, residents had repeatedly asked for entertainment. In some teams, this request was finally met by the inclusion of music in the group process. We found that this response

to residents' indications of the desired ambiance--in this case, music--served as a vehicle for recall and the bridging of life experiences.

The case of one elderly resident provides an example of this. A 99 year old man (who had been a singer in his early years) occasionally sang songs to the group; this usually occurred toward the end of group sessions. It was noticed that his choice of songs often paralleled recollections of important periods in his life. Using the song as a stimulus, the TOUCH Team was able to facilitate discussion of his feelings. Other group members then joined in, so that leaders were able to promote group processes and socialization, using life review techniques.

Another result was that goals for residents had to be reset at realistic levels. For example, it was understood that appropriate goals for a resident might be merely that he/she get out of bed, dress reasonably, and come to group, or that a resident respond in at least an elementary manner to others in the group.

A number of other findings have resulted from our experience with TOUCH Teams:

-- The Teams are supported by the various structures of the mental health center, and the same participant selection and group establishment processes were employed in each. Yet despite the care and the support, we found it took at least 6-8 weeks before a productive group process began to emerge in any of the TOUCH Team groups.

-- As mentioned, support is offered to TOUCH Team staff participants. In the first phase of the endeavor, ad hoc meetings and regular Team meetings prevented members from becoming so depressed themselves that it would necessitate leaving the program. Unfortunately, as the program progressed, clinical personnel were not always able to take advantage of these meetings--other priorities in the Center called them away. We have found that,as a result, the character of involvement has changed.

The attendance of volunteer TOUCH Team personnel at these meetings has not flagged; these volunteers are currently working with other professional staff on the development of a case management system for the provision of services to older persons (see presentation by Dr. Ross).

-- At a more mundane level, we found that residents were unwilling to sign forms about whose meaning they were uncertain. The Teams were financially dependent on Medicare reimbursement; and this necessitated the opening of full charts for medical records. This was especially difficult. Intake workers were unaccustomed to working in an outreach setting, and homes do not always maintain adequate records regarding medical needs and Medicare coverage (account numbers, copies of cards, etc.). But, most of all, clients are wary about signing any consent forms.

Teams have found that explaining the need for consent signatures--and actually obtaining them--is most effectively done during the group sessions. We have also developed a letter to be sent to a relative (or some significant person in the life) of a participant, explaining the process, its possible benefits, and the details of the Medicare procedure. The hope is to provide residents with backup assurance about the legitimacy of our procedures.

D. SOME SUGGESTIONS

A review of our experience with this group therapy format leads, at a minimum, to the following conclusions and recommendations:

-- Training which includes examination of realistic expectations (of both staff and clientele), should precede entrance into the board and care system.

-- Such training should, additionally, provide team members with a wide variety of group formats which might be needed and useful in working with an older, institutionalized population.

-- The importance of regularly scheduled team meetings (in which matters of technique and case issues are discussed) must be emphasized.